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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

BARBARA BLUM, *ET AL.*,
Petitioners,
v.
WILLIAM YARETSKY, *ET AL.*,
Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECO.. ..CUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

To the Honorable Chief Justice
and Associate Justices of the
Supreme Court of the United States

The National Citizens' Coalition for Nursing Home Reform respectfully moves this Court, pursuant to Supreme Court Rule 42(1), for leave to file the accompanying brief in this matter as *amicus curiae* in support of respondents. In support of this motion, the Coalition submits the following statement:

The National Citizens' Coalition for Nursing Home Reform, formed in 1975, is a national organization comprised of one hundred seven local community advocacy groups and many individuals who are actively involved in issues of nursing home reform and advocacy throughout the United States. The Coalition's goal is improving the quality of life for the 1.3 million people, five percent of the nation's elderly population, who live in nursing homes. The Coalition has particular interest in questions concerning empowerment of nursing home residents, quality of life and care in nursing homes, and enforcement of federal and state nursing home laws and regulations. The Coalition participated as *amicus curiae* in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980), the first case before this Court addressing issues of nursing home residents' rights.

The Coalition in a brief *amicus curiae* wishes to address the state action issue before the Court and specifically to set forth the legislative history of the skilled nursing and intermediate levels of care that are at issue. This legislative history shows that level of care determinations made by nursing homes and physicians are not part of any historical practice in long-term care, but rather, are statutory terms that were invented by Congress and enacted for purposes of fiscal control. It indicates that level of care determinations are made solely because of statutory directive and not because of traditional health care practice. This legislative history is relevant both to refuting petitioners' claim that level of care determinations are medical decisions and to showing how a finding of state action in level of care determinations is required by this Court's state action decisions.

Respondents consent to the filing of this brief *amicus curiae.* It is the policy of petitioners, New York State, however, not to take any position on motions for leave to file briefs *amicus curiae.*

Respectfully submitted,

By _____

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INTEREST OF *AMICUS* NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

The National Citizens' Coalition for Nursing Home Reform is a national organization comprised of one hundred seven local community advocacy groups and many individuals who are actively involved in issues of nursing home reform and advocacy throughout the United States. Of particular interest to the Coalition are questions concerning empowerment of nursing home

residents, quality of life and care in nursing homes, and enforcement of federal and state nursing home regulations.

This case, involving the issue of state action in long-term care facilities, is of particular importance to Coalition members.

SUMMARY OF ARGUMENT

The Second Circuit in the decision below recognized that whenever long-term care facilities or physicians make decisions to transfer Medicaid-supported nursing home residents to new facilities providing a different level of care, those decisions affect the enjoyment of public benefits and therefore must comport with Constitutional standards. *Yaretsky v. Blum*, 629 F.2d 817, 819-820 (2d Cir. 1980).

Petitioners argue that level of care decisions made by facilities, physicians or utilization review committees (when the decisions result in transfers to higher levels of care) are medical decisions not involving state action. By labeling all level of care decisions "medical," petitioners attempt to suggest that the decisions are part of traditional practices and not dependent on state authority. The falseness of petitioners' argument is revealed, however, by the breadth of their claim. It cannot be reasonably contended that level of care decisions made by facilities are medical. Indeed the documented absence of medical practitioners from long-term care facilities[1] makes plain the inaccuracy of that claim.

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[1] Subcomm. on Long-Term Care, Senate Comm. on Aging, *Nursing Home Care in the United States: Failure in Public Policy. Supporting Paper No. 3: Doctors in Nursing Homes: The Shunned Responsibility*, 94th Cong., 1st Sess. (Feb. 1975).

More fundamentally, petitioners' argument must fail because petitioners misconstrue levels of care and the level of care decision-making process.

Skilled nursing and intermediate levels of care, enforced through utilization control mechanisms, are creations of the Medical Assistance statute. Both concepts were placed in the Medicaid law in order to promote primarily fiscal goals. Neither has any basis in the traditional practice of medicine in long-term care, and, as a result, neither is ever applied to residents who pay personally and directly for their long-term institutional care.

Since level of care determinations are statutorily-directed administrative functions, whoever makes these determinations is performing an administrative function. While nursing homes and physicians may in other instances in the long-term care setting be performing traditional long-term care or medical functions, whenever they are engaging in level of care decision-making, they are performing administrative functions to which a finding of state action properly attaches.

ARGUMENT

I.

THE SKILLED NURSING AND INTERMEDIATE LEVELS OF CARE ARE STATUTORY CONSTRUCTS CREATED FOR PURPOSES OF FISCAL CONTROL IN THE MEDICAL ASSISTANCE PROGRAM.

The Medical Assistance Program reimburses nursing homes for providing nursing home care to Medicaid recipients if the care is provided at the skilled nursing or intermediate care level. A skilled nursing facility (SNF) is defined as providing "skilled nursing care . . . or

other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis." 42 U.S.C. § 1396d(f).[2] An intermediate care facility (ICF) is defined as one which provides "health-related care and services" at a lesser level of intensity than a skilled nursing facility offers. 42 U.S.C. § 1396d(c)(1).

Petitioners argue that decisions involving changes in level of care for nursing home residents do not implicate state action doctrine. Critical to their argument is the thesis that level of care decisions are medical decisions which the State simply honors by adjusting Medicaid payments made on recipients' behalf. This thesis is both factually inaccurate and fatal to defendants' state action analysis.

A. Legislative History of Levels of Care

The legislative history of the two levels of institutional long-term care makes plain that cost containment, rather than recognition of concepts of medical practice, motivated legislation in this area.

When Congress initially enacted the Medical Assistance Program in 1965, it authorized reimbursement for one

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[2] Medicare created a level of long-term care originally called "extended care." Social Security Amendments of 1965, § 102, 42 U.S.C. § 1396x(h), (i), (j). Congress was motivated by economic factors. "Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients." S. Rep. No. 404 (Finance Comm.), 89th Cong., 1st Sess., reprinted in [1965] U.S. Code Cong. & Ad. News 1943, 1971. In contrast to Medicaid, however, Medicare has never been extended to cover a lower level of long-term institutional care.

level of institutional long-term care called skilled nursing care. 42 U.S.C. §§ 1396a(a)(28), 1396d(f).[3] The Congressional purpose of creating such a level of care was to reduce the need for more costly care in acute care hospitals.[4]

From almost the moment of its enactment, Congress became concerned with the cost of the Medical Assistance Program. A 1967 Senate Finance Committee report accompanying amendments to the Social Security Act noted, "The committee has followed the developments of the medical assistance program with deep concern over its rapidly rising costs."[5] At that time, only two years after the enactment of Medicaid, Congress began to implement a series of cost-savings measures, such as

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[3] In fact there was little discussion of the Medical Assistance Program in the 1965 amendments to the Social Security Act which created it. Medicaid was the "sleeper" amendment appended to the administration's Medicare bill. Within Medicaid itself, little attention was paid to nursing homes at all. Vladeck, B. *Unloving Care—The Nursing Home Tragedy* 50, 48 (1980).

[4] "*Cost efficiency* constituted the Congressional rationale for financing care outside acute facilities, and federal legislation was not guided by any documentation of the *therapeutic effectiveness* of such care." [Emphasis in original.] Mitchell, J., "Patient Outcomes in Alternative Long-Term Care Settings," 16 *Medical Care* 439, 440 (June, 1978). Other authors have also concluded that concern over rising acute care hospital costs motivated Congressional enactment of long-term care in nursing homes. *See*, for example, Moroney, R., et al., "The Evolution of Long-Term Care Institutions" in Sherwood, S., ed., *Long-Term Care: A Handbook for Researchers, Planners, and Providers* 105 (1975).

[5] S. Rep. No. 744 (Finance Comm.), 90th Cong., 1st Sess., reprinted in [1967] U.S. Code Cong. & Ad. News 2834, 3013.

limitations on federal financial participation for the medically needy program[6] and the requirement that states provide home health benefits for persons eligible for skilled nursing facility services.[7] Congress also created a new lower level of institutional long-term care, which it called intermediate care, for categorically needy recipients.[8]

Congressional motivation was explicitly financial.[9] The Senate Finance Committee Report on the Social Security Amendments of 1967, P.L. 90-248, expressed concern with the fact that only skilled nursing care was reimbursable under Medicaid. The result, the Committee reported, was that Medicaid recipients were classified as needing "skilled nursing home" care "and placed in such institutions because of a decided financial advantage to a State under present matching formulas."[10] The overutilization of skilled nursing facilities suggested to the Committee that "a strong case exists for introducing another level of care for which vendor payments would be available."[11] The Miller amendment proposed by the Senate and adopted by Congress created this new level of care under Title XI of the Social Security Act, which

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[6] *Id.*, at 3013.

[7] *Id.*, at 3029.

[8] Categorically needy Medicaid recipients are those whose eligibility is based on their receipt of cash assistance benefits. 42 U.S.C. § 1396a(a)(10)(A), 42 C.F.R. §§ 435.100 et seq. Coverage of these persons is mandatory in the Medical Assistance Program. *See Beltran v. Myers*, 101 S.Ct. 1961 (1981).

[9] Pollak, W., *Expanding Health Benefits for the Elderly. Volume 1: Long Term Care* 10 (1979); Moroney, *supra* note 4, at 109.

[10] Senate Report, *supra* note 5, at 3027.

[11] *Id.* Vladeck calls this process "Inventing the ICF." Vladeck, *supra* note 3, at 63.

was called intermediate care. The Senate Finance Committee expected that the new lower level of care would remove states' financial incentive to classify Medicaid recipients as needing skilled care and thus save money.

> This amendment could result in a reduction in the costs of title XIX, by enabling States to use lower cost facilities more appropriate to the needs of thousands of persons, thus avoiding the higher charges for skilled nursing homes when care of that kind is not needed.[12]

The summary of the Social Security amendments presented on the Senate floor makes plain the financial reason for creating the new lower level of care:

> *Federal Matching for Assistance Recipients in Intermediate Care Facilities*
>
> Under current law, vendor payments may be made with Federal sharing only in behalf of persons in medical facilities, such as skilled nursing homes. There is no Federal vendor-payments matching for people who need institutional care in the intermediate range between that which is provided in a boarding house (for which eligible persons may receive a money payment under the money payment programs), and those who need the comprehensive services of skilled nursing homes.
>
> The committee bill would provide for a vendor payment in behalf of persons who qualify for OAA, AB or APTD, and who are living in facilities which are more than boarding houses but which are less than skilled nursing homes. The rate of Federal sharing for payments for care in those institutions would be at the same rate as for medical assistance under title XIX. Such homes would have to meet

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[12] Senate Report, *supra* note 5, at 3027.

> safety and sanitation standards comparable to those required for nursing homes in a given state.
>
> This provision should result in a reduction in the cost of title XIX by allowing States to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower cost institutions.[13]

The new level of care was called "intermediate" apparently because, in the Committee's view, it would be care in the "intermediate range" between boarding homes and skilled nursing homes.

Congressional amendments in 1971 which made intermediate care available for medically needy Medicaid recipients[14] confirmed the cost-saving purpose of the ICF level of care. Senator Long, chairman of the Senate Finance Committee, supported the Harris-Bellmon amendment extending ICF benefits to medically needy recipients:

> In order to provide a less costly institutional alternative to skilled nursing home care, the Committee and the Congress approved in 1967 an amendment to title XI of the Social Security Act which authorized Federal matching for a new classification of care provided in "intermediate care facilities."[15]

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[13] 113 Cong. Rec. 32599 (Nov. 15, 1967).

[14] Medically needy recipients are those whose income and/or resources are too high to qualify for cash assistance benefits but whose medical expenses are high enough that the State permits them to "spend-down" and establish Medicaid eligibility. 42 U.S.C. § 1396a(a)(10)(C), 42 C.F.R. §§ 435.800 et seq., *see Beltran v. Myers, supra* note 8. Coverage for these recipients is optional with States.

[15] 117 Cong. Rec. 44721 (Dec. 4, 1971). This language, placed in the Congressional Record by Senator Long, would have been

[footnote continued]

According to the Senate Finance Committee, the 1971 amendment was intended

> to clarify congressional intent with respect to intermediate care and to make such care, where appropriate, more generally available as an alternative to costlier skilled nursing home or hospital care.[16]

Just as the 1967 amendment creating intermediate care was intended to reduce reliance on skilled nursing care for categorically needy Medicaid recipients, the 1971 amendment extending ICF coverage to medically needy Medicaid recipients was intended to reduce their reliance on more costly SNF care.[17]

This legislative history makes plain that skilled nursing and intermediate care are concepts having significance only in the context of the Medicaid (and Medicare) statute. They are not pre-existing medical terms that Congress, in enacting the Medical Assistance Program, recognized and adopted.[18] Rather, they are concepts

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Senate Finance Committee Report language if the amendment extending ICF care to medically needy recipients had been added by the Committee.

[16] *Id.*

[17] *Id.*

[18] Indeed a medically-derived system of levels of care is not possible and would not make sense in long-term care. While long-term care residents have medical needs, they also and predominantly have social needs. Residents are institutionalized as much because of the absence of social networks that can provide care informally and because of the existence of a payment system for institutional (but generally not for non-institutional) care as because of purely "medical" needs. Comptroller General, "Entering a Nursing Home—Costly Implications for Medicaid and the Elderly," PAD-80-12 (Nov. 26, 1979); Pollak, *supra* note 9,

[footnote continued]

created out of whole cloth by Congress to ensure primarily fiscal goals. Congress invented different statutory "levels of care" for fiscal reasons, then mandated that States enact strict utilization controls in order to ensure that "excessive" care at government expense is not provided.

B. Levels of Care in Practice

In practice, level of care principles have served three distinct administrative functions for the Medical Assistance Program:[19] classifying residents,[20] classifying facilities[20] and setting Medicaid reimbursement rates.[21]

Whatever their value in classifying facilities and setting rates, levels of care are arbitrary and essentially meaningless with respect to resident classifications.[22]

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at 1-8 ("Lower medical and technical intensity, greater relative and absolute importance of social care elements, and different goals are the essential characteristics of long-term care that differentiate it from acute care." p. 8). Long-term care is fundamentally different from acute care and cannot have acute care's medical principles neatly superimposed.

[19] Bishop, C., et al., "Nursing Home Levels of Care: Problems and Alternatives," 2 *Health Care Financing Review* 33 (Fall, 1980).

[20] Facilities participating in the Medical Assistance Program are classified, and accordingly certified, as able to provide skilled or intermediate care, or both, depending on the facility's preference. The classification determines which Conditions of Participation a facility must satisfy for Medicaid certification.

[21] Reimbursement decisions follow facility level of care certification. Although Medicaid reimbursement for long-term care facilities has undergone repeated statutory change since 1965, a general guiding principle has always been that intermediate care is cheaper than skilled care.

[22] *See* Vladeck, *supra* note 3, at Chapter 6, "The Game of Levels."

That levels of care fail to identify the actual needs of long-term care residents in any coherent fashion is made plain by national statistics on States' utilization of the two levels of care. According to data prepared by the Department of Health, Education and Welfare (now Health and Human Services), in 1973, 1.8% of Medicaid recipients in long-term care facilities in Louisiana were in SNFs and 98.2% in ICFs. In the same year the reverse occurred in Florida: 89.3% of Medicaid recipients in long-term care facilities were in SNFs and only 10.7% were in ICFs.[23] No difference in the actual needs of long-term residents can account for such wide disparity among States in utilization rates of the two levels of care.

II.

UTILIZATION CONTROL ACTIVITIES, CONDUCTED BY FACILITIES AND PHYSICIANS, ENFORCE LEVEL OF CARE PRINCIPLES.

Level of care principles are enforced through statutorily-mandated utilization control mechanisms. A primary purpose of utilization control activities is ensuring that Medicaid recipients are placed in the proper level of care.

The Medicaid statute requires participating States to develop procedures to safeguard against the unnecessary

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[23] Community Research Applications, Inc., *Excerpt Summary of a National Study of Levels of Care in Intermediate Care Facilities (ICFs).* Prepared for Health Services Administration under Contract Number HSA-105-74-176, April, 1976. (Issued by Bureau of Quality Assurance, Health Services Administration, Public Health Service, U.S. Department of Health, Education and Welfare.) As reprinted in Vladeck, *supra* note 3, at 138. *See also* Pollak, *supra* note 9, at 11.

utilization of all Medicaid-covered services, 42 U.S.C. § 1396a(a)(30). For noninstitutional services, federal regulations permit States to perform utilization control activities on a sample basis. 42 C.F.R. § 456.22.

In order to give effect to the statutory levels of care which it created, however, Congress enacted a significantly more comprehensive program of utilization control for institutional services. Utilization control activities for institutional long-term care encompass not only utilization review, 42 U.S.C. § 1396a(a)(30), but also medical review in SNFs, 42 U.S.C. § 1396a(a)(26)(A), independent professional review (IPR) in ICFs, 42 U.S.C. § 1396a(a)(31)(A), inspection of care and services for SNFs and ICFs, 42 U.S.C. § 1396(a)(26)(B), (C), and 42 U.S.C. § 1396a(a)(31)(B), (C), respectively, and a variety of facility and physician obligations. Facilities are specifically required to conduct and participate in utilization control activities as a condition of participation in the Medical Assistance Program. 42 U.S.C. § 1396a(a)(28), incorporating 42 U.S.C. § 1395x(j) for SNFs (especially 42 U.S.C. § 1396x(j)(8), (12)), 42 U.S.C. § 1396d(c) for ICFs.

As respondents demonstrate in their brief, these statutorily-mandated utilization control activities place obligations on facilities and physicians to take an active role as partners with the State in controlling utilization of long-term care services. Independent of the utilization review process, facilities and physicians have additional statutory obligations to ensure that Medicaid recipients are placed in the proper level of care. The responsibilities of the State, on the one hand, and facilities and physicians, on the other, to conduct utilization control activities are mutually reinforcing and flow in both directions. An attending physician must make

an initial determination that a Medicaid recipient needs a particular level of care, 42 C.F.R. § 456.270 for SNFs, 42 C.F.R. § 456.370 for ICFs, and that decision must be reviewed by the State agency for each Medicaid recipient. 42 C.F.R. § 456.271 for SNFs, 42 C.F.R. § 456.371 for ICFs. Similarly, all reports of inspection of care teams must be sent to facilities and to their utilization review committees, as well as to the State agencies, 42 C.F.R. § 456.612.

States, however, have the final responsibility to ensure that utilization control mechanisms are effective. Failure to establish an effective utilization control program subjects States to loss of federal matching funds. 42 U.S.C. § 1396b(g), 42 C.F.R. §§ 456.650 *et seq.* Significantly, the federally-mandated sanction applies to utilization control activities conducted by facilities and physicians. States which cannot show, for example, that physicians are certifying and recertifying the need for inpatient care may have their federal share reduced. 42 U.S.C. § 1396b(g)(1)(A), 42 C.F.R. § 456.652(a)(1). Similarly, physicians' failure to establish and review each Medicaid recipient's plan of care subjects States to loss of federal funds. 42 C.F.R. § 456.652(a)(2).

Utilization control, made necessary by level of care requirements, is carried out jointly by the State, facilities and physicians in mutually dependent functions for which the State has final and complete responsibility.

III.

LEVEL OF CARE AND UTILIZATION CONTROL REQUIREMENTS ARE NOT APPLIED TO PRIVATE-PAY RESIDENTS.

While level of care and utilization control are central to the Medical Assistance Program, they play no role whatsoever when residents pay directly for their own care.[24] Private-pay residents may buy whatever care they want at whatever level they choose. Federal Medicaid law places no restrictions on the private choices of private-pay residents.

Physicians do not make level of care determinations about their private-pay patients. While they may prescribe medications and courses of treatment and engage in other traditional functions of medical practice for their patients who reside in nursing homes, they have no need to make non-medical determinations of level of care.

Utilization control is also absent from the life of a private-pay nursing home resident. Utilization control activities begin either when a Medicaid recipient is admitted to a facility or when a private-pay resident exhausts personal financial resources and applies for Medical Assistance. 42 C.F.R. § 456.333(a), (b) for SNFs, 42 C.F.R. § 456.433(a), (b) for ICFs. So long as a resident remains private-pay, he is free to occupy whatever nursing home bed he likes.

New York State's argument that a finding of no state action in this case leaves Medicaid residents in the same position as private-pay residents (Petitioners' Brief, p. 37) is disingenuous. It is plain that but for the require-

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[24] Comptroller General, *supra* note 18, at 103.

ments of the Medical Assistance Program, no level of care decisions and transfers would ever be made.

IV.

STATE ACTION IS PROPERLY FOUND WHENEVER LEVEL OF CARE DECISIONS ARE MADE BY UTILIZATION REVIEW COMMITTEES, FACILITIES OR PHYSICIANS.

Level of care decisions, whether made by utilization review committees, long-term care facilities, or physicians, constitute state action within the meaning of this Court's decisions.

As demonstrated above, the Medical Assistance statute invented the concepts of skilled nursing and intermediate levels of care for institutional long-term care and then required States to enforce those concepts through a comprehensive utilization control program. But for the Medical Assistance statute, level of care determinations and the utilization control activities which enforce them would not occur in long-term care.

Level of care decisions are totally unlike the enforcement of creditors' liens in *Flagg Brothers, Inc. v. Brooks*, 436 U.S. 149 (1978), and the termination of utilities in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974). While the Court observed that Flagg Brothers would enforce its liens "even in the absence of . . . authorization" of any state statute, 436 U.S. at 163 n.12, no similar claim can be made that facilities and physicians would make level of care determinations in the absence of Medicaid requirements. They do not make these decisions for private-pay residents.

The initiative to conduct level of care determinations does not come from any traditional practice of long-term health care, as did procedures for terminating utilities in

Jackson, 419 U.S. at 357. Indeed, not only has the State "put its own weight on the side of the proposed practice [of requiring level of care determinations] by ordering it," *Jackson*, 419 U.S. at 357, but it has also specifically mandated that level of care determinations be made in the first instance. The fact that the impetus for the challenged activity comes directly and exclusively from law, and not from the private parties' own historical practices, directly and conclusively distinguishes this case from *Flagg Brothers*, *Jackson* and *Moose Lodge v. Irvis*, 407 U.S. 163 (1972).

When facilities and physicians are engaging in their traditional practices, state action may or may not be present. This case need not decide whether all aspects of institutional long-term care are covered by state action doctrine. When facilities and physicians are performing the function of making level of care determinations that are mandated by the Medical Assistance law and would not be made but for that law's explicit requirements, however, state action is properly found. *Polk County v. Dodson*, 50 U.S.L.W. 4077, 4080 (Dec. 14, 1981). *Accord*, *Estelle v. Gamble*, 429 U.S. 97 (1976); *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

CONCLUSION

For all of the reasons outlined above, *amicus* urges affirmance of the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

By _____

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